STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING _____ B. WING _____	C 09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF SHELBYVILLE	2309 S MILLER ST SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the investigation of complaint # IN00116282. This visit was in conjunction with a Recertification and State Licensure Survey. This visit resulted in an extended survey-immediate jeopardy. Complaint # IN00116282 unsubstantiated due to lack of evidence. Survey dates: September 19, 20, 21, 24, 25, and 26, 2012 Extended survey dates: September 27 and 28, 2012 Facility number: 000009 Provider number: 155022 AIM number: 100274760 Survey team: Karina Gates, BHS TC Courtney Mujic, RN Beth Walsh, RN Census bed type: SNF/NF: 90 Total: 90 Census payor type: Medicare: 12 Medicaid: 61 Other: 17 Total: 90 Sample: 7 Heritage House was found to be in compliance	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155022	A. BUILDING _____ B. WING _____	C 09/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HOUSE OF SHELBYVILLE	**2309 S MILLER ST SHELBYVILLE, IN 46176**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 with 42 CFR part 483 Subpart B and 410 IAC 16.2 in regard to the investigation of complaint # IN00116282 survey. Quality review completed 10/5/12 Cathy Emswiller RN	F 000		